BEFORE THE

STATE OF CALIFORNIA

OCCUPATIONAL SAFETY AND HEALTH

APPEALS BOARD

In the Matter of the Appeal of: GLASS PAK 5000 Fulton Drive Suisun City, CA 94585 Employer	Docket Nos. 03-R2D2-750 and 751 **DECISION AFTER RECONSIDERATION**

The Occupational Safety and Health Appeals Board (Board), acting pursuant to authority vested in it by the California Labor Code and having taken the petition for reconsideration filed by the Division of Occupational Safety and Health (Division) under submission, renders the following decision after reconsideration.

JURISDICTION

On December 19, 2002, a representative of the Division initiated an investigation of an injury occurring at a place of employment maintained by Glass Pak (Employer) at 5000 Fulton Drive, Suisun City, California.

On February 11, 2003, the Division issued two Citations. Citation 1 contained two items, one regulatory and one general. Item 1 alleged a violation of section 342(a)[1], which was initially appealed. The Employer withdrew its appeal at the hearing, and the $250 proposed penalty was imposed. Item 2 alleged a General violation of section 3284(b) [wearing gloves near entanglement hazard]. The Employer appealed the existence of this violation, and asserted the Independent Employee Action Defense (IEAD).

Citation 2, Item 1, alleged a Serious violation of section 3314(a) [employee adjusted conveyor that was not de-energized]. The Employer challenged the existence and classification of the violation, and alleged lack of employer knowledge and IEAD. The proposed penalty was amended to $20,250 on motion by the Division, without objection by Employer.

[1] All references are to Title 8, California Code of Regulation, unless indicated otherwise.

Hearings were conducted over the course of two days, and extensive evidence was submitted.

On April 26, 2006, the ALJ issued his Decision, finding no violations other than the section 342(a) violation, as to which Employer had withdrawn its appeal. The section 3284(b) and section 3314(a) violations were found not to exist because the employee so exceeded the scope of his employment that violations should not be sustained. The Decision also considered and rejected Employer's IEA defense, and the defense of "employee malfeasance."

The Division filed a timely petition for reconsideration challenging the conclusion that the employee so exceeded the scope of his employment that no violations could be found. The Employer answered, contending the application of *J.R. Wood, Inc.,* Cal/OSHA App. 95-4431, Decision After Reconsideration (Oct. 14, 1999), to these facts was appropriate, and in the alternative, the defense of "employee malfeasance" existed and applied to this case to relieve it of any violations. The Employer did not challenge the rejection of its other affirmative defenses.

The Board took the petition for reconsideration under submission on June 29, 2006. After a review of the entire record, the Board issues this Decision After Reconsideration, reversing the Decision and finding the Division established both contested violations, but failed to establish the Employer knew or should have known of the existence of the violations. Thus, the classification of Citation 2 is reduced to general, and appropriate penalties are hereby imposed.

EVIDENCE

The evidence in the record consists of the testimony of six witnesses, including the injured worker, the Division investigator, a former employee, both owners of Employer, and an expert on conveyor belts. The documentary evidence consisted of the Employer's Illness and Injury Prevention Plan (IIPP), a written energy control procedure, witness statements and other items, including three photographs, submitted to the Division on request during the course of the investigation.[2]

[2] Photographs and diagrams offered through the testimony of the expert were not admitted as they were not of the sprocket and chain drive where the accident occurred. Although the expert examined the correct main disconnect switch on the conveyor where the accident occurred, there are multiple sprocket and chain assemblies on that line, and the evidence does not establish that he examined the actual assembly where the injury occurred, and the exact dimensions and configurations of the various sprocket and chain drives are not identical throughout line #1.

On Saturday, November 30, 2002, Employer's maintenance employee entered the closed facility to perform routine maintenance on conveyor lines. In so doing, he wore gloves while reaching in to touch the chain of a sprocket and chain assembly that was energized. His fingers became entangled in the sprocket and he sustained permanent injuries to his hand, including bone loss from the tip of one finger.

The maintenance undertaken that day included servicing motors and sprocket and chain drive assemblies that were integral components of the conveyor systems at the glass re-packaging and refinishing facility. The several conveyor lines are comprised of multiple, similar segments. Conveyor line #1, where the accident occurred, receives its electrical power through a main disconnect switch on a control panel some feet away from the conveyor. Electricity will not flow from the main disconnect switch to any segment of the conveyor until the "on" button, located six to eight inches from the main disconnect switch, is depressed. In addition, for each segment, a toggle-type on-off switch also controls the power to the segment.

There was no evidence of machine malfunction. The injured employee admitted the main disconnect switch was in the "on" position when he placed his hand on the chain near the sprocket. The start button had to have been depressed, and the toggle-type segment switch was either accidentally engaged due to a lack of locking it out, or it remained in the "on" position when the servicing action was undertaken. Evidence for each scenario was presented by witnesses whose credibility was questioned by the ALJ.[3] The expert witness examined the wrong sprocket and chain drive on conveyor number one. An owner of Employer, Marc Silvani, investigated the accident site the next day, and photographed a damaged glove with blood on it, and concluded there from that the injured worker was wearing gloves at the time of the accident.[4]

Since the IEAD was alleged for both Citations, much testimony and documentary evidence was offered regarding the safety procedures, discipline, training, and the lock out/tag out policies and procedures at Employer. The Employer also challenged the serious classification of Citation 2, Item 1, and so evidence was offered concerning the supervision and training of the injured worker. On these topics, the testimony of the disinterested former employee, Jeff Iribarron, was credited by the ALJ. It corroborates other, less reliable evidence from both the Employer witnesses and the injured employee regarding the extent of training the injured worker had, the extent of supervision provided for the maintenance workers, and the appropriateness of the injured worker servicing the conveyor at the time he did, which was when the facility

[3] Footnotes 4, 18 and 25 in the Decision identify portions of testimony of the Employer's witness, Marc Silvani, which lacked credibility. Footnotes 2, 11 and 18 identify portions of the testimony of the injured employee that lacked credibility.

[4] Silvani was found credible regarding this portion of his testimony.

was closed.[5] Iribarron's testimony also provides substantial evidence on the actual safety procedures in place at Employer regarding de-energizing machines.

The actual procedure used by the maintenance department employees to de-energize machines differed from the written policy. Maintenance employees de-energized the machines without tagging them out, and without consistently using locks. Rather, de-energizing was accomplished by placing the main disconnect switches in the "off" position prior to servicing.[6] This was done without incident for at least four and one half years preceding the injury.

The extent of training in the maintenance department was also established through testimony. The record supports the conclusion that in spite of a lack of formal training provided to the injured employee on the written lock out/tag out procedure, he was known to be consistently compliant with, and had actual knowledge of, the rule that all machines must be de-energized prior to any maintenance. In fact, he trained Iribarron on the actual procedure of de-energizing before servicing. There is no reliable evidence that formal training on the written lock out/tag out policy (dated February 2002) or any other procedure was ever undertaken. We infer from the length of his service, his successful training of another employee, and a lack of injury for over four years[7], that he was fully trained on the de-energizing practice actually in place, to wit, that the main disconnect switch must be in the "off" position before any servicing may be conducted. Also, Dallas Nelson, another owner of Employer, assigned the injured worker to identify and report safety violations throughout the plant. The evidence supports the conclusion that the injured employee was well trained to perform maintenance duties required by employer.

The evidence regarding supervision establishes that the injured worker, though not a supervisor of any other employee at the time of the injury, supervised himself in large measure. Silvani appears to have retained the authority to direct the work activities of the injured worker, but left the day to day tasks to the injured worker. The record establishes that Silvani participated in rebuilding and refurbishing parts of the conveyor machinery (during and after a move of the facility), but that he did not direct the day to

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[5] The ALJ found one Employer witness, Silvani, and the injured employee, to have testified unreliably in multiple aspects (see footnote 3), though neither testimony was entirely rejected as lacking credibility. (*Mechanical Asbestos Removal Inc. dba Marcor*, Cal/OSHA App. 86-362 Decision After Reconsideration (Oct. 13, 1987).)

[6] The employer's written lock out/tag out policy required tags, locks, and step by step instruction for each machine. A copy of the policy was submitted in to evidence as Employers Exhibit R. On page three it states, "All equipment that contains energy will be locked out prior to being serviced or maintained" and "All employees who are authorized to work on equipment or machinery in the company will follow appropriate company lockout/tagout procedures."

[7] We limit this inference. Here, the lack of injuries supports the inference that this worker was adequately trained for his job. The lack of prior injuries does not necessarily merit the inference that training, in a general sense, was adequate.

day operations of the maintenance department during the time Iribarron worked for Employer, 2000 to 2002. His level of involvement in day to day maintenance after that time, i.e. in the 4-6 months preceding the accident, is unclear from the record. Since there is no evidence of any change in the actual supervision provided by Silvani during the few months prior to the injury from that testified to by Iribarron, we conclude Employer did not regularly supervise the injured worker during his routine maintenance activities up to and at the time of the accident. Instead, it appears the injured worker determined the servicing and maintenance needs of the various machines, and then undertook that work by himself, with tacit approval from all members of management.

The Employer's testimony regarding a policy purportedly requiring two employees to service a conveyor together was effectively contradicted by Iribarron, who testified that he routinely de-energized conveyor lines alone, including line #1, and that many times he would work with the injured worker for part of the morning, and then get instructions from the injured worker and continue assigned service and maintenance tasks by himself.

Employer's IIPP was developed to its current state in February 2002, nine months before the accident, and four months before Iribarron left Employer. It contains, among other things, eleven job hazard evaluations, but none for either maintenance department position. The IIPP does not contain any requirement that maintenance work on conveyors is to be done by two people. There were no written records of any safety training provided to the injured worker, though he *conducted* two safety meetings regarding other jobs at the facility in the course of his responsibilities as "Safety Director" under the written IIPP. Dallas Nelson, the administrative manager/owner, testified he appointed the injured worker to the position of "Safety Director" in July 2002, as the person at the 70 person facility authorized to identify and report safety violations. Although the IIPP lists the injured worker as the person responsible for safety at the facility, in fact the other managers held the authority to reprimand workers for safety violations. The injured worker was only charged with observing and reporting safety violations, and delivering written reprimands initiated by Bob Sotl or another manager. He and owner Dallas Nelson testified consistently in this regard.

The written policy contained provisions for progressive discipline for safety violations. In practice, some managers issued verbal and then written warnings, and thus followed the written policy. Marc Silvani did not give any warnings other than verbal warnings. De-energizing by following the unwritten procedure, rather than the written lockout/tag out policy, did not result in any written reprimand or any verbal reprimand from Silvani, the owner who was ultimately responsible for the machinery at the facility. Nor did it result in any discipline from the other managers who were actually authorized to reprimand workers for safety violations, to wit, Dallas Nelson, Bob Sotl, and Tom Pernell.

On the day of the accident, the employee was not violating any company policy when he let himself in to the building to work alone performing maintenance on conveyor #1. No rule prohibited working alone, and he had authorization to work some overtime on the Thanksgiving holiday weekend. The injured worker and the Employer disagree on the date set for him to perform the routine maintenance.

ISSUES

1. Whether the employee so exceeded the scope of his job duties that the Employer should be relieved of liability for the violation.

2. Whether the factors of the Independent Employee Action Defense were properly considered.

3. Whether a defense for "employee malfeasance" exists here.

REASONS FOR DECISION AFTER RECONSIDERATION

I. The evidence establishes a prima facie case of both contested violations.

Citation 1, Item 2, alleges a general violation of section 3384(b) [employee wearing gloves near an entanglement hazard]. Silvani's statement supports the conclusion that the injured employee was wearing gloves when the injury occurred. Furthermore, the Division witness provided sufficient evidence of the entanglement hazard posed by a moving sprocket and chain assembly. A violation of section 3384(b) was established. (*Cambrio Manufacturing Co.*, Cal/OSHA App. 84-923, Decision After Reconsideration (Dec. 31, 1986).)

Likewise, the violation alleged in Citation 2, Item 1, was established by a preponderance of the evidence. That Citation alleged a Serious violation of section 3314(a) [equipment capable of movement shall be de-energized and, if necessary, locked out to prevent inadvertent movement during servicing]. The employee admitted leaving the main disconnect switch in the "on" position which conflicts with the procedure required for de-energizing equipment prior to servicing. Without any evidence of machine malfunction, the only reasonable inference to draw from the evidence is that the power button was also pushed, and that the segment toggle switch was not locked out, or was in the "on" position. The Division has established a violation of section 3314(a) and the analysis in the ALJ Decision in this regard is sound. (*Cambrio Manufacturing Co, supra.*)

The violation of section 3314(a) was properly classified as serious. An opinion about the substantial probability of serious physical harm or death must be based upon a valid evidentiary foundation, such as expertise on the subject, reasonably specific scientific evidence, an experience-based rationale, or generally accepted empirical evidence. (R. *Wright & Associates, Inc., dba Wright Construction & Abatement*, Cal/OSHA App. 95-3649, Decision After Reconsideration (Nov. 11, 1999).)

Division witness, Jones, testified to over twenty years experience supervising and training employees on maintenance of sprocket and chain devices. He personally witnessed several accidents where fingers were injured or amputated by being drawn in to the sprocket and chain device. His opinion, based on this and other accident investigation experience, led him to conclude that the most likely injury resulting from an accident that occurs while servicing energized sprocket and chain devices was amputation. Thus, the Division has met its burden to prove the violation was Serious.

II. The employee performed his regular work in a manner not prohibited by Employer. Unknown to Employer, however, he disregarded a basic safety rule of which he was aware. Thus the Serious classification has been overcome by evidence that Employer did not and could not with the exercise of reasonable diligence, have known of the violation.

The Division asserts in its Petition for Reconsideration that the Decision misapplies the holdings in *J.R. Wood, supra* and *Andersen Tile Company,* Cal/OSHA App. 94-3076, Decision After Reconsideration (Feb. 16, 2000), to create a new defense. We conclude that neither *J.R. Wood* supra nor *Andersen Tile supra* applies to this case, as the employee here did not encounter an unknown hazard or so exceed the scope of his regular work to constitute an "extreme departure." This case is fully resolved under the terms of Labor Code section 6432 and cases interpreting that statute.

Labor Code section 6432 allows an employer to successfully challenge the Serious classification of a violation if it "can demonstrate that it did not, and could not with the exercise of reasonable diligence, know of the presence of the violation." The injured worker was alone when he serviced the conveyor, and disregarded the well-established rule that the main disconnect switch must be in the "off" position before any servicing of machines could be undertaken. There is substantial evidence on which to conclude Employer did not actually know of the violation.

We also conclude the Employer could not have known of the violation with the exercise of reasonable diligence. "[We] have held that, in order to meet its burden to show reasonable diligence, an employer must demonstrate that the hazard occurred at a time and place that deprived it of a reasonable

opportunity to detect it. *Bickerton Iron Works, Inc.*, Cal/OSHA App. 01-4978, Decision After Reconsideration (Feb. 25, 2004)." (*Irby Construction,* Cal/OSHA App. 03-2728, Decision After Reconsideration (Jun. 8, 2007).) The violation occurred when the employee was working alone after hours, thereby depriving the Employer of the ability to detect the violation.

When the violation occurs as a result of an employee disregarding a safety rule, the question becomes whether the Employer's supervision was adequate.

> Whether an employer could have reasonably detected a violation is determined on a case-by-case basis. The Board has indicated that adequate supervision of employees is an important consideration. Whether such supervision was present depends upon several factors, including: (1) the hazardousness of the work being performed (see KenKo, Inc., Cal/OSHAB App. 90-1101, Decision After Reconsideration (Jan. 6, 1992); (2) the number of employees involved (see D. A. Whitacre Construction, Inc., Cal/OSHAB App. 90-775, Decision After Reconsideration (Aug. 8, 1991); (3) prior indications that violations might occur (see Star-Kist Foods, Inc., Cal/OSHAB App. 83-781, Decision After Reconsideration (Oct. 16, 1987); and (4) the frequency and length of periods employees work unsupervised (see Steiny and Company, Inc., Cal/OSHAB App. 90-944, Decision After Reconsideration (Sept. 11, 1991); Lockheed-California Company, Cal/OSHAB App. 82-1212, Decision After Reconsideration (May 15, 1985).)

(*Roof Structures, Inc.*, Cal/OSHA App. 91-316, Decision After Reconsideration (Oct. 29, 1992).)

In *Roof Structures, supra* the classification was reduced from Serious to General because the supervisor, viewing roofing employees from the ground, could not identify that the rigging was improper, and there was no indication that constant supervision was required for the regular work of this experienced employee. Since the employer exercised reasonable diligence and failed to identify the hazard, the employer overcame the Serious classification under section 6432.

The record here supports the conclusion that Employer could not have discovered the violation with the exercise of reasonable diligence because the injured employee was working on a Saturday, when the facility was closed, without the knowledge of the employer. Applying the principles of *Roof Structures supra*, we conclude Employer provided adequate supervision of this employee while he performed routine tasks for which he was unquestionably well trained. (See *Lockheed-California Company*, Cal/OSHA App. 82-1212,

Decision After Reconsideration (May 15, 1985) and *Lift Truck Services Corporation*, Cal/OSHA App. 93-384, Decision After Reconsideration (Mar. 14, 1996).)

Considering the Employer assigned the injured worker to identify safety hazards and violations throughout the plant, and to report them to management for disciplinary action, and that this employee had supervised and trained another employee on correctly performing this very task, which he and another employee routinely performed without supervision, Employer was not lax in failing to supervise his after-hours, routine maintenance work. Thus, the evidence establishes that the Employer could not have known of the violation in the exercise of reasonable diligence. As such, the violation's classification is reduced to General.

We conclude that neither *Andersen Tile, supra*, nor *J.R. Wood, supra,* apply to the facts of this case. When an employer specifically instructs a worker on the scope of his work, or otherwise establishes the employee in fact knows the limits of the assigned work, and the employee chooses to exceed those limits and does the work in a manner that violates safety rules, the employer can show it neither knew nor could have known about the violation. This has the effect of reducing the classification to General, but does not result in a finding of no violation. (Labor Code § 6432; *Andersen Tile, supra*.)

Here, Employer regularly allowed its maintenance mechanics to perform routine maintenance, and to de-energize the conveyors, independently and without direct supervision. The disinterested witness, Iribarron, testified he routinely serviced conveyor machines without direct supervision[8], and de-energized the machines by merely turning the main disconnect switch to the "off" position. Thus, working independently to do routine maintenance was allowed. Like the worker in *Andersen Tile supra*, the injured worker here was performing his regular work, though at a time or place that was not authorized by the employer. While doing this work, he disregarded a basic safety rule of which he was aware. Thus, our holding in *Andersen Tile supra* does not apply here to vacate the violation, but only operates to reduce the classification.

The evidence establishes Employer had a written lock out and tag out policy that it did not train its employees on, did not require its employees to follow, by not supplying tags or requiring locks, and did not discipline its employees for deviating therefrom. It actually trained its employees on a de-energizing procedure that did not comply with either its own written plan, or existing Safety Orders, according to the disinterested witness, Iribarron. Even

[8] The Employer's witness, Silvani, and the injured worker, testified that the weekend maintenance was anticipated. Silvani's assertion that Friday was the agreed upon time was credited by the ALJ. The ALJ did not credit Silvani's other assertion that the maintenance work required two people because of Irebarron's testimony to the contrary.

though the employee was working at a time when he was not authorized to work, he was performing his regular work, and as such, the violation cannot be considered the extreme departure enunciated in *Anderson Tile, supra*. Had employer been enforcing its written safe work methods, then an employee working at a time outside of what was anticipated might constitute such a departure. (*Newbery Electric Corp. v. Occ. Safety and Health Appeals Board* (3rd Dist 1981) 123 Cal. App. 3d 641, and *Gaehwiler v. Occ. Safety and Health Appeals Board* (1st Dist. 1983) 141 Cal. App. 3d 1041.)

Finally, although the employee's disregard of a basic, well known safety rule was perhaps unexpected, the lack of foreseeability of the employee's action does not negate the violation. (*Andersen Tile*, *supra*.). We distinguish the concept of foreseeability articulated in *J.R. Wood* from the circumstances in this matter. In *J.R. Wood supra*, the Board concluded no employer would reasonably identify the hazard in the workplace.[9] Here, the hazard was not only identified by the Employer, but a rule was created to protect against exposure to the hazard. *J.R. Wood* is inapposite.

III. Affirmative Defenses

1. Independent Employee Action Defense

Employer raised the Independent Employee Action Defense (IEAD) in its Appeal, and the defense was considered in the Decision. While we agree that not all of the necessary elements were presented by Employer, and so the defense must fail, we reach this conclusion on different grounds than those stated in the Decision. The IEAD absolves the employer of liability if the violation was committed by non-supervisory employees, and the employer has acted reasonably in creating policies and procedures to avoid the actual harm encountered by the non-compliant employee. (*Mercury Services, Inc.*, Cal/OSHA App. 77-1133, Decision After Reconsideration (Oct. 16, 1980).) The five elements of the defense are designed to assure the Employer has taken all reasonable steps to avoid employee exposure to the hazard, but the employee's own actions have circumvented or frustrated that effort. (*Id.*; *Marine Terminals Corporation*, Cal/OSHA App. 95-896, Decision After Reconsideration (Sep. 28, 1999).)

> To prevail on the defense, the employer must establish <u>all</u> of the following elements: (1) that the injured employee had experience in the job being performed; (2) that it had a well devised safety program; (3) that it effectively enforced the safety program; (4) that it had a policy of applying sanctions for violations; and (5)

[9] In *J.R.Wood*, the supervisor reached a finger in to a screw auger pipe that contained a blade edge, and there was no reason for the employer to anticipate any employee would reach in and so encounter such a hazard.

> that the employee causing the infraction knew he was acting contra to the employer's safety requirement. (*Mercury Services, Inc.*, Cal/OSHA App. 77-1133, Decision After Reconsideration (Oct. 16, 1980).)

(*Dade Behring, Inc.*, Cal/OSHA App. 05-2203, Decision After Reconsideration (Dec. 30, 2008).)

Element 1 was found by the ALJ to be established, and the record supports this conclusion.[10]

Element 2 requires the employer to prove it has a well devised safety program. The Decision finds the program has two technical IIPP defects pursuant to Cal. Code of Regs, Title 8, section 3202, and thus concludes this element has not been met. While the program may or may not qualify as "well devised," we conclude that the reasons listed in the Decision for finding the element lacking are insufficient to support that conclusion.

The "missing" IIPP elements that defeat element two in the Decision are that the injured worker's name remained on the IIPP as the person responsible for implementing the plan, and that the training records of the injured employee were not submitted, as he did not sit through formal training on lock out/tag out. However, the record as a whole supports the conclusion that the management team was actually responsible for implementing the IIPP, and that the injured worker was designated to identify and report safety violations to those responsible parties. One of the owners, Dallas Nelson, credibly testified that the injured worker was listed on the IIPP to be the "eyes and ears on the floor" charged with reporting violations to management, who would then act appropriately. The fact that managers made decisions based on those reports, rather than the named person required under section 3203, does not require a conclusion that the plan is not "well devised" for purposes of the IEAD.

Next, the lack of training records for the injured worker do not undermine the quality of the safety program in light of the substantial evidence establishing the injured worker was actually well trained, and in fact, successfully trained another worker to de-energize and service the conveyors. Although the IIPP regulation certainly describes a well devised safety program,

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[10] The injured employee has performed maintenance on the conveyor machines, after first de-energizing the lines at the main disconnect switch, for upwards of four years while employed at Employer. He was sufficiently well trained in his maintenance duties to effectively train another worker on the maintenance duties. That training included teaching and enforcing the rule that the main disconnect switch on line #1 must be in the "off" position before maintenance or service can be performed thereon. Also, the administrative manager, Dallas Nelson, was sufficiently assured of the injured worker's competence regarding the safety rules for the entire plant, not just the maintenance functions, that he appointed the injured worker as the individual responsible for identifying and reporting any safety violation. Element 1 is established.

the IEAD does not require full compliance with section 3203 in order to establish this element. Given the Division's failure to cite the Employer for IIPP violations, and given the evidence that the missing components were accounted for in other ways[11], we find the analysis of element 2 in the Decision to be incomplete. Rather, this element should be analyzed by taking a realistic view of the written program and policies, as well as the actual practices at the workplace.

There was a substantial amount of additional evidence that should have been considered in determining if the Employer's program was "well-devised." The Division witness testified that he considered the Employer's safety program to be "effective." The program was in writing, and contained provisions for progressive discipline for safety violations. Although the Plan is dated February 2002, and the employer had been in business for many years before that date, a new plan is not necessarily a poorly devised one. We hesitate to fault an employer who has seen the error of its prior ways and has made efforts to develop a plan that the Division inspector concluded was "effective." Since the purpose of the Act is to encourage, through inspections and appropriate fines, employer compliance with safety regulations, the late date of the written plan does not undermine its potential efficacy.

In addition, the paperwork that evidences the program contains safety job analyses of specific positions undertaken by Tom Pernell, the production manager. There are also records of safety meetings held in 2002, with multiple departments, to discuss safety concerns tailored to these specific positions. There is also a written lock out / tag out policy specific to each conveyor line. There was testimonial and documentary evidence indicating the managers, including Marc Silvani, Bob Sotl, and Tom Pernell, gave oral and some written warnings to employees throughout the plant. And, Iribarron testified he was regularly reprimanded for violating workplace rules, including safety rules, and that he had received oral and written warnings for these infractions, even before the IIPP was put in to place.

However, although job evaluations were performed for some positions, no job analyses were conducted regarding either maintenance worker. Also, even though there was a written lock out / tag out program, there appears to have been limited or no compliance with that written plan, per the testimony of Iribarron. Considering that tags or warning signs on control switches are, and were in 2002, mandatory when servicing this kind of equipment [3314(c) (West 2010) and 3314(b)(West 2003)], it appears the procedure actually followed was in direct conflict with general industry safety orders as well as Employer's own

[11] The injured worker was in fact adequately trained, despite the lack of records of training, and the persons responsible for implementing the IIPP were Dallas Nelson, Marc Silvani, Bob Sotl and Tom Pernell, in spite of the injured worker's name being on the plan. Having actual training, and having owners and managers actually responsible for safety overcomes the facial defects on the IIPP for purposes of the IEAD.

written policy. Also, in spite of the written policy to implement a progressive disciplinary program, and evidence that other supervisors may have complied therewith, the practice of Marc Silvani of only issuing verbal warnings undermines the overall quality of the safety program. This evidence provides a sounder basis to conclude element 2 was not established.

In any event, we conclude that the third element of the IEA defense has not been established on this record, and so agree that the defense as a whole must fail. "The third element—that Employer effectively enforced its safety program, requires that evidence of meaningful enforcement of a well-devised safety program must be presented." (*Tri-Valley Growers*, Cal/OSHA App. 94-3355, Decision After Reconsideration (Sep. 15, 1999).)

The Decision relies on two facts to conclude elements 3 and 4 are not satisfied. It relies on the lack of written warnings by Marc Silvani, the owner responsible for maintenance operations (even though there were "numerous" verbal warnings) and the lack of the use of tags in the de-energizing program. Indeed, the Employer was not consistent in utilizing its progressive discipline program. The practice of owner Marc Silvani, of giving only verbal warnings for safety violations, was somewhat effective in that it led to the injured worker similarly giving frequent verbal warnings to the employee he supervised. As a result, that employee, Iribarron, testified that he knew of, and always followed, the rule that the main disconnect switch on conveyor line #1 must be in the "off" position prior to servicing. Verbal warnings can be effective. We do not draw the inference of inadequate enforcement simply from a lack of writing, as the ALJ decision does. However, inconsistent enforcement of written policies, and inconsistent use of the progressive discipline policy, can amount to ineffective enforcement of an otherwise well devised plan.

The second shortcoming identified in the Decision, in addition to other evidence, does justify the conclusion that enforcement was inadequate. Although the evidence is strong that the employer generally enforced other aspects its safety program (*Dade Behring, supra*), the record also shows that the written de-energization policy was not followed in several respects. The lack of tags, the inconsistent use of locks (at the discretion of the employees per Iribarron)[12], and the failure to evaluate the maintenance position, evince a general disregard of the written lock out / tag out policy, which was an integral part of the maintenance employee's work. Employer tolerated a practice that varied substantially from its own written program.[13] Such lax enforcement of a written lock out / tag out policy establishes the Employer was not reasonably diligent in enforcing its safety plan. (*Paso Robles Tank, Inc.*, Cal/OSHA App.

[12] Iribarron testified that locks were kept in a maintenance room, and he was trained to get one and use it if he concluded one was needed. He testified there were no tags provided by Employer.

[13] Furthermore, the safety orders make placement of tags or warning signs at the control switches mandatory when servicing such equipment. (3314(c) (West 2010) and 3314(b)(West 2003).

08-4711, Denial of Petition for Reconsideration (Nov. 2, 2009).)[14] Thus, we conclude the record establishes a meaningful deficiency in the Employer's enforcement of the written lock out / tag out portion of its overall safety plan.[15] Since the hazard cited falls within this unenforced policy, we conclude that element three has not been shown by the Employer by a preponderance of the evidence.

Having a satisfactory written program, but not following it in actual practice, in this case undermines the Employer's ability to establish it has a well-devised, effectively-enforced safety plan. (*Mercury Service, supra).* Since the failure to prove any one of the elements negates the defense in its entirety, the IEAD was not established by Employer. (See *Ferro Union, Inc.*, Cal/OSHA App. 96-1445, Decision After Reconsideration (Sep. 13, 2000).)

2. Malfeasance

In its Appeal, and again in its Answer to the Petition for Reconsideration, Employer asserts that there exists a defense to these violations for "employee malfeasance" citing *Metalclad Insulation Corp.*, Cal/OSHA App. 96-130, Decision After Reconsideration (Oct. 4, 2000). That case expressly refused to recognize such a defense, stating the Employer's argument was nothing more than the re-characterization of an employee's failure to abide by a known safety rule. We hold the same applies here.

IV. Penalties

The proposed penalty for Citation 1, Item 2, was $500.00. The Employer only contested the existence of the violation, not its classification or the proposed penalty. The penalty worksheet was admitted in to evidence, and reflects the original penalty calculation of $2000.00, with 50% adjustment given for low extent and likelihood, and another 50% credit given for abatement. We conclude the proposed penalty is reasonable given the nature of the hazard and the scope of the violation. (*System 99, A Corporation*, Cal/OSHA App. 78-1259, Decision After Reconsideration (Aug. 30, 1982).)

The proposed penalty for Citation 2, Item 1 was amended to $20,500 from the original proposed penalty of $22, 500. The Employer contested the existence of the violation, as well as its classification, but not the proposed

[14] We distinguish cases where this element was not established based on a credibility finding by the ALJ. See *Columbia Helicopters, Inc.*, Cal/OSHA App. 01-623, Decision After reconsideration (Jan. 8, 2004).
[15] This evidence may establish Employer knowingly violated sections 3314(b) and (c). Since the Division chose not to issue citations for these violations, the issue is not before us. (*Benicia Foundry and Iron Works*, Cal/OSHA App. 00-2976, Decision After Reconsideration (Apr. 24, 2003).)

penalty.[16] Since the evidence supports a General classification, we conclude, applying the same credits as were applied in Citation 1, that a penalty of $500.00 for this item is similarly reasonable. (*System 99, supra.*) Including the penalty for the uncontested violation [342(a)], the total penalty of $1,250.00 is hereby imposed.

CANDICE A. TRAEGER, Chairwoman
ART R. CARTER, Member

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[16] Contesting the classification of the violation automatically raises the issue of the reasonableness of the proposed penalty. *Watkins Contracting, Inc.*, Cal/OSHA App. 93-1021, Decision After Reconsideration (Sep. 24, 1997).